STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street, 23rd Floor
San Francisco, California 94105

INITIAL STATEMENT OF REASONS

RH05043720
November 13, 2006

NETWORK PROVIDER PROVISIONS IN HEALTH INSURANCE POLICIES AND AGREEMENTS

INTRODUCTION AND DESCRIPTION OF THE PUBLIC PROBLEM

California Insurance Commissioner John Garamendi ("Commissioner") proposes the adoption of changes to the following article in the California Code of Regulations:

- California Code of Regulations, Title 10, Chapter 5, Subchapter 3, Article 6, sections 2240 through 2240.4, entitled "Exclusive Provider Provisions in Group Disability Policies and Agreements"
- Adoption of a new California Code of Regulations, Title 10, Chapter 5, Subchapter 3, Article 6, section 2240.5

Proposed Changes

The purpose of the proposed regulation is to make changes and additions to California Code of Regulations, Title 10, Chapter 5, Subchapter 3, Article 6 that will implement, interpret, and make specific the provisions of California Insurance Code section 10133.5, as amended by Assembly Bill 2179. The proposed changes apply to health insurers which contract with network providers for alternative rates pursuant to Insurance Code section 10133. Insurance Code section 10133.5 is the authority for the proposed regulation.

The proposed regulations implement, interpret, and make specific the provisions of section 10133.5. For example, to avoid confusion and ambiguity, the proposed regulations will apply to all health insurers which contract with network providers for alternative rates, instead of just exclusive providers. To ensure that covered persons have timely and appropriate access to covered health care services, specific criteria are established to clarify for insurers the provider access standards to which they will be held. To ensure that network providers are treated fairly and that their contracts with insurers protect against discrimination in timely access to care by covered persons, the proposed changes to the regulations require that provider contracts be fair and reasonable as well as requiring the filing of these contracts with the Department of Insurance. To ensure that the covered persons understand they have a statutorily-conferred right to complain if they do not receive timely access to health care, the proposed changes to the regulations require that all covered persons be provided notice of where to file complaints. The

proposed changes also require insurers to file annual reports regarding complaints they have received about timely access to health care and how those complaints were resolved.

The proposed regulations are reasonably necessary to carry out the intent of the Legislature in amending section 10133.5 of the Insurance Code. The Commissioner proposes the adoption of these regulations pursuant to the authority vested in him by sections 10133 and10133.5 of the California Insurance Code.

The proposed regulations are reasonably necessary to carry out the intent of sections 10133 and10133.5 of the California Insurance Code in that they require the commissioner to promulgate regulations applicable to health insurers which contract with providers for alternative rates pursuant to Section 10133 to ensure that covered persons have the opportunity to access needed health care services in a timely manner. The Commissioner proposes the adoption of these regulations pursuant to the authority vested in him by sections 10133 and 10133.5 of the California Insurance Code.

Discussion of Public Problem

The Commissioner has received reports of repeated instances in which covered persons did not receive the access to health care they should have and had no manner of redressing these complaints. Further, there are disparate contracting provisions that may obligate providers to provide conflicting standards of health care services. Lastly, the notice requirements address the covered persons right to complain and the process by which complaints may be made if appropriate health care access is denied.

SPECIFIC PURPOSE AND REASONABLE NECESSITY FOR REGULATIONS:

The specific purpose of each regulation and the rationale for the Commissioner's determination that each regulation is reasonably necessary to carry out the purpose for which it is proposed is set forth below.

TITLE 10, CHAPTER 5, SUBCHAPTER 3, ARTICLE 6

SECTION 2240. **Definitions**

The purpose of this section is to define certain terms used in Insurance Code section 2240 through 2240.5 that would otherwise be unclear. The definitional sections are reasonably necessary to eliminate confusion about the meaning of the terms defined. New definitions include the phrase "Mental Health Care Services" and are defined in this section to set forth clearly that those services rendered under Insurance Code 10144.5 are within the health access services required under the regulations as amended. Another new definition proposed is the definition of 'Network' to establish that all institutions and types of providers of medical care are included in the requirements of the proposed regulations.

SECTION 2240.1. Adequacy and Accessibility of Provider Services.

Insurance Code section 10133.5 requires that these regulations shall be designed to assure accessibility of network provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract. The changes to section 2240.1 address this statutory mandate and insure the first two requirements of the statute, namely:
1. Adequacy of number and locations of institutional facilities and professional network providers, and consultants in relationship to the size and location of the insured group and that the services offered are available at reasonable times.
2. Adequacy of number of professional network providers, and license classifications of such network providers, in relationship to the projected demands for services covered under the group policy or plan, including consideration of the nature of the medical speciality in determining the adequacy of professional network providers.

The proposed changes to Section 2240.1 execute the statutory mandate and set forth the specific standards for health insurers that contract with providers for alternative rates pursuant to Insurance Code section 10133. Insurers are required to meet the mandated network access standards outlined in this section for ensuring timely access for covered persons to primary care physicians, specialty care physicians, hospital care, and other specified health care services.

This section which requires specific standards is reasonably necessary to set forth the health care standards required by Insurance Code section 10133.5 concerning the availability of primary care physicians, specialty care physicians, hospital care, and other specified health care services to ensure that enrollees have timely access to care.

The proposed changes to Section 2240.1 also address the situation faced by insureds that do not have timely access to needed health care services due to the lack of a contracted provider offering the health care needed by the insured.

SECTION 2240.2. Adequacy and Accessibility of Provider Services.

The few changes proposed to this section are necessary to make this section consistent with the other sections by removing the reference to "group" contracts since the regulations will apply to all contracts. The distinction of network versus non-network services assists in clarification of the health care services to be rendered and is needed for consistency.

SECTION 2240.3. Adequacy and Accessibility of Provider Services.

The changes proposed to this section are necessary to make this section consistent with the other sections by removing the reference to "group" contracts since the regulations will apply to all contracts. The distinction between network versus non-network services assists in clarification of the health care services to be rendered and is needed for consistency.

The requirement of a prominent disclosure pursuant to Insurance Code section 510 is necessary to ensure that all covered persons receive notice and instructions on how to complain should they not receive timely and appropriate access to health care needed. Further, the reference to Insurance Code section 510 will assist the department in its market conduct studies and enforcement of these regulations.

SECTION 2240.4. Insurance Contract Provisions.

Insurance Code section 10133.5 sets forth that these regulations shall be designed to assure accessibility of network provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract. The changes to section 2240.4 address this statutory mandate and ensure the second two requirements of the statute are met, namely: 1) The policy or contract is not inconsistent with standards of good health care and clinically appropriate care, and; 2) That all contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable.

The proposed changes to Section 2240.4 execute the statutory mandate and set forth the specific standards for health insurers that contract with network providers for alternative rates pursuant to Insurance Code section 10133 to act in a fair and reasonable manner when contracting with providers. In addition, the proposed changes to this section set out a requirement that all contracts between insurers and providers include a non discrimination provision that will protect insureds and help guarantee their timely access to needed covered health services consistent with the authorizing statute.

SECTION 2240.5. Filing and Reporting Requirements

The addition of the new section 2240.5 describes the new filing and reporting requirements as set forth in the mandating statute Insurance Code section 10133.5.

The reporting requirements include a " geoaccess" report showing the number and location of all network providers utilized by the insurer to provide services to covered persons and demonstrating that the insurer is in compliance with the accessibility and availability requirements of these regulations.

The filing with the department of complete copies of the most-utilized network provider contracts is also a requirement. This section further requires that insurers report annually to the Consumer Services Division of the Department of Insurance a detailed accounting of complaints received by the insurer regarding timely access to care with sufficient detail. This report is to include a summary of the receipt and resolution of complaints regarding timely access to care as well as availability of specific services as set out in the section.

These reporting requirements are necessary as they are the means by which the department may assure compliance with the access standards outlined in the regulations and the authorizing statute.

SPECIFIC TECHNOLOGIES OR EQUIPMENT

Adoption of these regulations encourages the use of the industry standard "Geonetworks/GeoAccess" computer software or an equivalent to apply and analyze the quantitative access standards outlined in the proposed regulations. However, comparable software programs that provide the same kind of analysis and results are permitted.

IDENTIFICATION OF STUDIES

There are no technical, theoretical, and empirical studies, or similar documents relied upon in proposing the adoption of the regulations. The Commissioner has relied upon the information received from affected insurers in the form of health access standards already used internally by insurers to benchmark their network against competitors. The Commissioner, in compliance with the authorizing statute, has also relied on consultations with the California Department of Managed Health Care in proposing the adoption of the regulations. The Commissioner in compliance with the authorizing statute has also researched comparable access standards used by other State entities including the State Department of Health Services and the State Department of Industrial Relations.

REASONABLE ALTERNATIVES TO THE REGULATIONS; IMPACT ON SMALL BUSINESS

The Commissioner has determined that no reasonable alternative exists to carry out the purpose for which the regulations are proposed or which would be as effective or less burdensome to affected private persons than the proposed regulations.

The Commissioner has identified no reasonable alternatives to the presently proposed regulations that would lessen any impact on small business.

ECONOMIC IMPACT ON BUSINESSES AND THE ABILITY OF CALIFORNIA BUSINESSES TO COMPETE:

The Commissioner has made an initial determination that the proposed regulations may have a significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. The types of businesses that may be affected are insurance companies. The Commissioner has considered performance standards, but the Commissioner has identified no performance standards that would be as effective as the proposed regulations in enforcing the statutes that form the basis for the proposed regulations. The Commissioner has not considered other proposed alternatives that would lessen any adverse economic impact on business and invites interested parties to submit proposals. Submissions may include the following considerations:

(i) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to businesses.

(ii) Consolidation or simplification of compliance or reporting requirements for businesses.
(iii) The use of performance standards rather than prescriptive standards,
(iv) Exemption or partial exemption from the regulatory requirements for businesses.

The Commissioner invites interested parties to comment on whether the proposed regulations will have a significant adverse economic impact on business.

PRENOTICE DISCUSSIONS

The Commissioner conducted a prenotice public discussion of the proposed regulations pursuant to Government Code section 11346.45. The Department mailed an Invitation to Prenotice Public Discussions to a number of insurer representatives on February 25, 2005. Subsequently, on April 5, 2005 the Department held a one-day workshop in order to receive comments on the proposed regulation. Input from workshop participants was taken into account in the formulation of the proposed regulation.